Summary

1 The Indian Health Design Team, a task force of Indian leaders and Indian Health Service (IHS) officials, has recommended changes in the organization and operation of the IHS. This report, our second, takes into account progress towards implementing the recommendations we made in our November, 1995 report and additional feedback from Indian Country regarding restructuring Area level components of the IHS. Our recommendations are in response both to industry wide external forces affecting health care practice and financing, and internal forces such as increasing contracting of IHS programs by Indian tribes.

2 After studying the problems, we concluded that one design could not fit all the diversity found within the Indian health system. The differences among localities are too great. We focused on restructuring the support system (Area Office and Headquarters components) on which many of our hospitals and health centers depend for support work not done onsite.

3 We did not recommend closing Area Offices. We considered consolidating Area Offices for a time, but this idea was not supported widely by Indian tribes and communities. We suggested other ways to restructure this support work. These ideas include: recommending Area Offices form sharing arrangements for work that each has trouble doing alone; asking Area offices to transfer work to hospitals and health centers that is better done locally; and, asking Area offices to change from controllers to suppliers of support services. These changes are scheduled to begin in 1997 and to be completed in 1998.

4 We also recommended changes at IHS headquarters to bring leadership in line with empowering front line health care programs. There are three key changes: Headquarters is reducing layers and streamlining by combining 132 components into less than 50 components grouped into 3 offices; Selected components that pay for or support field programs will be transferred to the field; and we gave Headquarters new core functions to advocate for Indian health, advance the community based approach to health care, document Indian health needs, and support a nation-wide Indian health network. Completion is scheduled for 1997.

5 As our system moves toward increasing local autonomy and responsibility, the individual hospitals and health centers face risks of rising costs, lost buying power, and vulnerability that are related to their relative small size and, in many cases, geographic isolation. To reduce these risks, Indian hospitals and health centers need to cooperate to share capabilities, leverage buying power, and create a bigger voice together. Today, advanced communications technology offers the possibility to connect together Indian hospitals and health centers located anywhere in the United States. As participants in an nation-wide Indian health network, each hospital and health center could access capabilities not available locally. In this way, individual Indian health programs can realize the benefits of cooperation and gain flexibility to fit local needs. Investment in a nation-wide Indian health network is essential to achieving a level of collaboration necessary to offset risks related to size and geographic isolation.

6 Concurrent with the structural changes that we envision, the IHS also must shift to a more business-like way of conducting internal operations. The Business Plan Workgroup recommended changes in four key segments of IHS business practices that complement the structural changes proposed in our report. These include ways to increase revenues through third party collections, ways to control cost increases and maintain financial solvency, ways to manage increasing transfers of IHS components and resources to tribes, and ways to bring other business-like approaches to internal management and operations. Like our restructuring plan, all features of the business plan can not be realized immediately. The plan identifies a timetable to accomplish recommended changes over a 2-3 year time period.